Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5737AGZ	A. BUILDING _____ B. WING _____	01/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK MEMORY CARE SAN MARTIN	**7230 GAGNIER BLVD LAS VEGAS, NV 89113**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an initial State Licensure survey. A Policy and Procedure manual review was initiated on 12/14/09, the onsite survey was conducted in your facility 1/5/10, and the facility was determined to be in compliance with the regulations on 1/7/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is requesting to be licensed for 64 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. Four employee files were reviewed. Deficiencies identified during the off-site and on-site review were corrected by 1/7/10. No further action is necessary. Please retain a copy of this report for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE